Editorial Column

Access to Care: Remembering Old Lessons

More than 20 years ago, Penchansky and Thomas (1981) published an article titled "The Concept of Access: Definition and Relationship to Consumer Satisfaction." In the opening sentence to this article, they note: "'access' is a major concern in health care policy and is one of the most frequently used words in discussions of the health care system." The same is certainly true today. In many policy discussions, access is equated with health insurance coverage. Although those who have defined access have all included other, nonfinancial, aspects of access in their definitions (Donabedian 1973; Penchansky and Thomas 1981; Millman 1993), we must still often remind ourselves of the importance of each aspect and the interplay between the different aspects.

As conceived by Penchansky and Thomas, access reflects the fit between characteristics and expectations of the providers and the clients. They grouped these characteristics into five *A*s of access to care: affordability, availability, accessibility, accommodation, and acceptability. *Affordability* is determined by how the provider's charges relate to the client's ability and willingness to pay for services. *Availability* measures the extent to which the provider has the requisite resources, such as personnel and technology, to meet the needs of the client. *Accessibility* refers to geographic accessibility, which is determined by how easily the client can physically reach the provider's location. *Accommodation* reflects the extent to which the provider's operation is organized in ways that meet the constraints and preferences of the client. Of greatest concern are hours of operation, how telephone communications are handled, and the client's ability to receive care without prior appointments. And finally, *acceptability* captures the extent to which the client is comfortable with the more immutable characteristics of the provider, and vice versa. These characteristics include the age, sex, social class, and ethnicity of the provider (and of the client), as well as the diagnosis and type of coverage of the client.

We must also remember that these five *A*s of access form a chain that is no stronger than its weakest link. For example, improving affordability by providing health insurance will not significantly improve access and utilization

if the other four dimensions have not also been addressed. Often neglected are the characteristics of the provider and the client that influence acceptability. Taylor et al. (2002) estimate that providing universal coverage through a Medicare buy-in for women aged 50–62 would result in a modest increase in mammography rates, from 72.7 percent to 75–79 percent. Like the work by Hofer and Katz (1996), who compared mammography rates for women in Canada and the United States, this research highlights the role in achieving access of client socioeconomic characteristics that influence acceptability.

Similarly, equating access with availability of resources will miss other characteristics of the provider and the clients that may be barriers to access. As Iwashyna et al. (2002) conclude, "intercounty heterogeneity in hospice use is substantial, and may not be related to the set-up of the medical care system." Their research also finds that simply controlling for differences in the composition of measured individual-level characteristics did not explain variation in use. Not only is the mere presence of facilities not an adequate measure of availability, it misses the more important issue of goodness of fit, that is, the interaction between the characteristics of the providers and the expectations of the clients that determine the acceptability of the resources.

Perhaps a more reliable measure of the goodness of fit between provider and client is whether someone has a regular physician and a regular site of care, since it can be seen as reflecting availability, accessibility, accommodation, and acceptability. The results of Xu (2002) highlight the importance of this goodness of fit between provider and client in influencing use of preventive services. However, the full picture on access does not emerge because the role of affordability in influencing utilization, controlling for differences in having a usual source of care, is not reported.

The growing body of research investigating racial and ethnic differences in the utilization of various medical and dental care services points to the critical role played by all of the dimensions of access, particularly availability, accessibility, and acceptability. Although Gilbert et al. (2002) found that affordability was certainly a barrier to access to adequate dental care for African Americans and non-Hispanic whites in their sample, also important were other nonfinancial predictors that varied in both significance and effect between the two groups.

The challenge to researchers is, first, to recognize the interdependence between the different dimensions of access, and second, and more difficult, to find appropriate measures of these dimensions. Only then will their findings

provide the basis for policy changes that will be truly effective in improving access.

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